

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address: NORTHWEST TEXAS HOSPITAL 3255 W PIONEER PKWY ARLINGTON TX 76013-4620	MFDR Tracking #:	M4-08-7243-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: American Casualty Company of Reading, PA Box #: 47	Date of Injury:	
	Employer Name	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Understanding that DWC of TDI is wanting to move to a hospital reimbursement of a % over Medicare, we have used that methodology in our calculations of [sic] 'fair and reasonable'. As a common practice, we review the **ER** charges **for at least a 75%** line item reimbursement. In addition the following line items should be reimbursed at [sic] the Medicare fee schedule x 125%, of the listed fee schedule... 70450... 72125... 72128... 72131... 76376... 72141..."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$691.66
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...28 Texas Administrative Code Rule 134.401 establishes a Division's per diem rate of \$1,118.00 for surgical procedures and \$870.00 for medical services performed on an inpatient basis... Carrier contends the per diem rate can be used as guidance for the establishment of a fair and reasonable payment for the services provided... The total recommended allowance represents a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in section 413.011 of the Texas Workers' Compensation Act."

Principle Documentation:

1. Response Package
2. EOBs

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
5/22/2007	W10(850-054), 97(855-013), W4(920-002)	Emergency Room Visit	\$691.66	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - W10 – “No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.”
 - (850-054) – “The recommended payments above reflect a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in section 413.011(d) of the Texas workers’ Compensation Act.”
 - M – “No MAR \$10.20”
 - M – “No MAR \$13.77”
 - M – “No MAR \$204.00”
 - M – “No MAR \$209.00”
 - M – “No MAR \$22.03”
 - M – “No MAR \$383.00”
 - M – “No MAR \$39.93”
 - M – “No MAR \$4.82”
 - M – “No MAR \$41.00”
 - M – “No MAR \$5.00”
 - M – “No MAR \$511.70”
 - 97 – “Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated”
 - (855-013) – “Payment denied – This service is included in the global value of another billed procedure. \$0.00”
 - W4 – “No additional reimbursement allowed after review of appeal/reconsideration.”
 - (920-002) – “In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.”
2. This dispute relates to outpatient emergency services including laboratory and radiological studies performed in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(a)(3) and §134.401(a)(5), effective August 1, 1997, 22 TexReg 6264, which provide that such services shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services.
3. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(c)(2)(B), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “a copy of each explanation of benefits (EOB) relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB.” This request for medical fee dispute resolution was received by the Division on December 14, 2007. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the initial EOB detailing the insurance carrier’s response to the original bill submission. Nor has the requestor provided convincing evidence of carrier receipt of the request for an EOB. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under Division rule at 28 TAC §133.307(c)(2)(B).
6. Division rule at 28 TAC §133.307(c)(2)(C), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division”... Review of the documentation submitted by the requestor finds that the documentation does not support that all of the services in dispute were rendered on the dates of service listed on the requestor’s *Table*. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under Division rule at 28 TAC §133.307(c)(2)(C).
7. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues”... Review of the requestor’s position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed under Division rule at 28 TAC §133.307(c)(2)(F)(iii).

8. Division Rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable”. The requestor’s position statement asserts that “we review the **ER charges for at least a 75%** line item reimbursement” However, review of the submitted documentation finds that the requestor did not discuss or explain how it determined that 75% line item reimbursement would result in a fair and reasonable reimbursement for the ER charges. The requestor additionally states that procedure codes 70450, 72125, 72128, 72131, 76376, and 72141 “should be reimbursed at the Medicare fee schedule x 125%” [sic]; however, the requestor did not discuss or explain how reimbursement at the Medicare fee schedule x 125% would yield a fair and reasonable reimbursement for those items. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodologies. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. The request for additional reimbursement is not supported. The Division concludes that the requestor has not submitted documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(c)(2)(G).
9. Additionally, the Division has determined that a reimbursement methodology based upon payment of a percentage of the hospital’s billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that
- “A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”
- Therefore, 75% line item reimbursement of the ER charges cannot be recommended. Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment of the amount sought by the requestor would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.
10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(B), §133.307(c)(2)(C), §133.307(c)(2)(F)(iii) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.250, §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

4/30/2010
Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.